EXHIBIT G

ECR PROCESSING INSTRUCTIONS, CRITICAL FIELDS AND CHECK LIST

ERROR CORRECTION REPORTS (ECR's)

The purpose of the Error Correction Report (ECR) is to inform providers of claim lines that were suspended due to an error in claim data submission. ECR's allow providers to make corrections to erroneous data.

A completed and appropriately corrected ECR will allow the Department of Alcohol and Drug Programs (ADP) to process the claims of those providers that had errors on their original claims.

Error Correction Reports must be **EXPEDITED.** All ECR's must be re-entered into the billing system within 97 days after the current date. If ECR's are not re-entered into the system within 97 days they will automatically be denied. The ECR's must be corrected and received by ADP within 8 weeks from the current date. The dte the ECR is due back to ADP is included in the cover letter, sent to the county or direct contract provider, with the ECR.

There are two types of ECRs: 1) the Edit ECR, and 2) the Duplicate ECR. Each type of report will be explained in more detail later in this section. There are general instructions which apply to both types of reports, and then each report has some information which applies only to it. A quick check list to help make sure your ECR is correct prior to submitting it to ADP can be found on Page G-21.

- Corrections to an Error Correction Report (ECR) must be made in **GREEN INK**, per requirement of the Department of Health Services (DHS) key entry section.

- **NEVER use an override code and make a correction on the same record.** If inappropriate corrections or override codes are used on an ECR the Automated Billing System will ignore them. The suspended units will remain suspended for the remainder of the 97 days and become denied.

- **Do not make an entry in the correction field when information is correct. The correction field is used only for amending incorrect information.**

- Units of service cannot be increased on an ECR. Submit a supplemental claim to increase the units of service for a client.

- If a client is listed on more than one record line for correction, each record line must be corrected. Making a correction to one record line corrects only that line.

- It is important to read the error messages on the ECR. The error messages will tell you what needs to be done to correct the problem causing the claim to be rejected.

GENERAL INFORMATION AND INSTRUCTIONS

EDIT ECR's

The Edit ECR contains miscellaneous errors regarding beneficiary eligibility and provider certification to provide the service being billed.

OVERRIDE CODES

The following is a list of override codes that are allowable for correcting Edit ECR's. They are:

- The **"A" through "F" override codes** are late submission codes from Title 22. If the ECR is affixed with a good cause code, a 'Good Cause Certification' form, ADP 6065, must be prepared and held at the provider site. DO NOT send the Good Cause Certification form to ADP unless Good Cause code is "D".

- The **"X" override code** will delete a record from the automated billing system. The "X" requires no backup documentation.

- The **"W" override code**, accompanied by the two digit county code and the two digit aid code, will override an **eligibility only** error message. This code is used only when you have proof that the information on the ECR is correct. This code should only be used as a last resort after all other correction methods have been exhausted. **If using a "W" override with a SSN or CIN, you MUST INCLUDE THE COUNTY CODE and THE AID CODE in the first four positions of the correction field leaving the remaining positions blank. All "W" override codes will be audited by our Audit section. If there is no POE on file at the program, an audit exception will be taken.**

Immediately following this page are the various reasons for an ECR to be generated. Possible solutions are also identified.

ERROR MESSAGES - EDIT ECRs

The following is a listing of possible error messages that appear on Edit ECR's that require correction. They are:

1. BLANK

Problem: The claim was submitted with incomplete information. Blanks were left on the form when submitted or there was a key entry error.

Solutions: Information that was missing on the original submission can be entered on the ECR in the correction field. No override code is needed.

2. CLAIM TOO OLD FOR ELIGIBILITY CHECK BY SSN

Problem: The claim is more than 30 months old and client eligibility cannot be verified by the computer system.

Solution: Verify the accuracy of the SSN for the month/year of service. If it is incorrect, make correction in the correction field.

If claim is older than 30 months, the ID number is correct, and the provider has POE, DO NOT RE-ENTER the SSN. Enter a "W" in the override code field to override the system (you must retain a copy of the POE when using the "W" override for future audits). Enter the county code and aid code in the first four positions of the SSN field.

The Department must request a special run from DHS to process any claim over 30 months old. This will happen under special circumstances only as defined by ADP.

3. CONFLICT W/DATE CLAIM RECEIVED

DHS must fix this problem. Notify ADP of the error for correction.

4. CONFLICTS WITH ELIGIBILITY FILE

Problem: The information provided (name, sex, year of birth) for the SSN does not match the eligibility history file in DHS's Automated Billing System.

Solution: The information submitted for the SSN; name, year of birth, or sex was incorrect or there was a key entry error. Verify the accuracy of the SSN against the POE. If the information is incorrect, enter the correct information in the correction field. If the information is correct, do not re-enter the information in the correction fields. Correct only those fields which are incorrect.

If the SSN is correct, and all other fields are also correct, submit the ECR to ADP along with a copy of the POE for the month/year suspended. DMC will do a comparison check through DHS to see why the claim is being rejected.

5. DATE RANGE NOT ALLOWED

Problem: A claim has been submitted using a range of dates for services that are required to be billed one unit of service per line. Possible errors: date range identified but not allowed; the service function code field is blank; or the provider has submitted the service function code incorrectly.

Solution: If the service function code is not correct, i.e., should have been 20 for NTP Methadone Dosing, enter 20 in the correction field.

If the service function code is correct and is for services other than NTP Methadone Dosing, then the service days in the reported range will have to be corrected to reflect one service day and one unit of services per record line (except for NTP counseling and ODF counseling where more than 1 unit can be reported on a single record line. After this correction, the dollar amount will be incorrect and there is not a means to correct it. If the $ amount is more than the maximum allowable rate, the automated billing system will approve only that maximum $ amount. All units of service in the reported range on the original claim cannot be reflected on the ECR. Therefore, a new claim must be submitted, with the remainder of the days in the original range, to ADP with "RESUBMISSION" written on the top, along with a copy of the corrected ECR page.

The most accurate means of making a correction to this message is to enter an "X" in the override code box to delete the claim from the automated system. After the denied claims report has been received, resubmit the claim by writing one day of service and one unit of service per line on a new claim marked resubmission. Submit a copy of the denied claims report with the resubmission. No further paper work is required.

6. DOLLARS GREATER THAN ALLOWED

Problem: The dollar amount billed exceeds the amount allowed.

Solution: Check to make certain the billed amount is not more than the maximum rate. Check to make sure the units of service for NTP counseling do not exceed the 200 minutes or 20 units limit. Make the appropriate corrections.

7. GREATER THAN TWO OUTPATIENT SERVICES

Problem: Three or more claims have been submitted for the same client for the same service days.

Solution: The submission of more than one service per day should only occur on an occasional basis. The normal is one claim per day and services are all inclusive. Only the occasional instance where a client has been in for a session and is required to return again for an additional session later in the day should be billed.

More than two visits are not allowed on one day unless crisis or collateral.

8. INELIGIBLE IN MO/YR

Problem: The SSN is not authorized for the month/year of the service claimed.

Solution: If client's SSN was submitted incorrectly or there was a key entry error, enter the correct SSN in the correction field. If the mo/yr is incorrect, make correction in the correction field.

If there is no proof of eligibility (POE) in your records, enter an "X" in the override code box to delete the client.

If the information on the ECR is correct, and the eligibility file is wrong, and you have the POE to verify the client eligibility, do not re-enter the information. Enter a "W" in the override field and enter the county code and the aid code in the first four positions in the correction field.

9. INVALID CODE

Problem: This error might appear in any of five different fields: Program Code, Provider Code, Mode of Service, Service Function Code, SSN or discharge. The entry on the claim may be an unidentified code or more/less numbers than required for a field.

Solution: If the code was submitted incorrectly or a key entry error is made, enter the correct code in the correction field. (ADP - If the program code is correct, check to ensure it is not a Department of Mental Health (DMH) provider (check DHS formatted dump.))

The swipe card 10-digit number may have been used. The SSN is the first 9 digits only.

10. VALID DIAGNOSIS CODE

Problem: The reported Diagnostic code from the DSM III/IV manual is not a drug or alcohol code. The Diagnostic Code is a five-digit code. Refer to the American Psychiatric Diagnostic Service Manual III/IV for the proper diagnostic code.

Solution: Compare the diagnostic code on the ECR against the client record. If the code is incorrect, make the required correction in the correction field.

If the diagnostic code is correct, the client is not a primary alcohol or drug client. Enter an "X" in the override box to delete the client from the system.

11. INVALID RECEIPT DATE

DHS must fix this error. Notify ADP of the error for correction.

12. INVALID SERVICE FUNCTION CODE

Problem: The service function code as reported by program code is not a service the provider is certified to provide.

Solution: The service function code may have been used in error by the provider. If the provider has been certified to provide Drug Medi-Cal services by ADP and your records indicate the program code, provider number and service function code are correct as billed, please contact ADP.

13. LATE SUBMISSION

Problem: The claim has been received at DHS past the sixty (60) day time limitation (due to ADP within 30 days and then due to DHS within the following 30 days).

Solution: If the claim was submitted after the time limitation and was not because of "good cause," this claim must be denied by putting an "X" in the override code box.

If the claim was submitted after the time limitation and meets the "good cause" requirements, enter the appropriate good cause code (see good cause codes in Title 22) in the override code box.

If the claim was submitted timely and it appears to be a key data entry error, contact ADP.

DO **NOT USE A "W"** IN THE OVERRIDE FIELD. The only override for this error is a "good cause" code or an "X" to delete the record.

NOTE: A "Good Cause Certification" form ADP 6065 must be prepared for all claims and ECRs that have been affixed with a "Good Cause" override code. **The form must be held at the provider site. Do not send the Good Cause Certification form to ADP, unless for Good Cause code "D", which must be submitted to ADP with the claims.**

14. MODE NOT AUTHORIZED

Problem: This message means the program code, service function code or mode of service are not appropriate for this particular provider.

Solution: Codes were either submitted incorrectly or there was a key entry error. If codes are incorrect, make corrections in the correction field.

Mode of Service - There are two different mode of service codes:

Mode 17 - Outpatient Clinic
Mode 12 - Hospital Outpatient Clinic

Most Alcohol and Drug Treatment facilities are Mode 17. Only a clinic residing in a hospital would be a Mode 12.

15. MODE NOT AUTHORIZED IN MO/YR

Problem: Claims have been submitted for months prior to the providers Drug Medi-Cal certification date.

Solution: Verify the accuracy of the provider number, program code, mode of service and service function code. If any of the codes are incorrect, make the required correction in the correction field.

Mode of Service - There are two different mode of service codes:

Mode 17 - Outpatient Clinic
Mode 12 - Hospital Outpatient Clinic

Most Alcohol and Drug Treatment facilities are Mode 17. Only a clinic residing in a hospital would be a Mode 12.

If all codes are correct according to your records, contact ADP for assistance.

16. MO/DATE GREATER THAN RECEIPT DATE

DHS must fix this error. Notify ADP of error to be corrected.

17. MO/YR OF SERVICE GREATER THAN RECEIPT DATE

Problem: The Month/Year of service provided on the claim is greater than the Mo/Yr the claim was received by DHS. The date may have been provided incorrectly by the provider or there could be a key entry error.

Solution: If the Month/Year is incorrect enter the correct date in the correction field.

18. NO SECONDARY MATCH

Problem: SSN does not match the sex, name, or year of birth of the client that is in the eligibility history file (EHF) maintained by DHS. Two out of three of the preceding matches must match to establish eligibility.

Solution: Check POE to verify that the SSN is correct and that there is no key entry error. Verify the spelling of the name as it appears on the POE, sex and year of birth. If the SSN is incorrect, make the correction in the correction field (usually if the SSN is incorrect, that will be the only correction required). Make entries in the correction field for name, year of birth, or sex only if they are incorrect.

If all information is correct, return the ECR to ADP with a copy of the POE. ADP will ask DHS to check the eligibility history file to determine why the error has occurred and advise the program on the required action.

19. NOT NUMERIC

Problem: This message might appear in any of seven different fields. In some instances there could be letters instead of numbers in the field.

Solution: Units of service and total amount fields may require leading zero's. Enter corrected numbers in the correction field.

20. NOT ON ELIGIBILITY FILE

Problem: The SSN does not appear on the DHS eligibility history file.

Solution: Verify the accuracy of the client's SSN against the POE. If the SSN was submitted incorrectly or there was a key entry error, make the required correction in the correction field.

If the client's SSN is correct, and the eligibility file is wrong, and you have POE, do not re-enter the ID number. Enter a “W” in the override field along with the county code and aid code in the first four positions of the SSN field.

If the client is not eligible, enter an “X” in the override field to delete the record from the system.

21. NOT ON PROVIDER FILE

Problem: Provider number is not on the approved payor list at DHS (formatted dump); or the program code submitted is incorrect.

Solution: If the provider number or program code is incorrect, make the appropriate correction.

If the provider number and the program code are both correct, re-enter one of those numbers in the correction field. The claim will be rejected again on an ECR giving the claim an additional 97 days on suspense. Notify ADP and the appropriate steps will be taken to have the DHS provider file updated.

If you submit a claim for a Program Code (20, 25) for which you are not certified, a "Revised" invoice must be submitted for the Program Code for which you are certified.

22. NOT VALID DATE

Problem: The date submitted on the claim (month/year) was a later date than the current date; the date was not complete; or there was a key entry error.

Solution: Enter the correct Mo/Yr in the correction field.

23. NOT VALID DAY

Problem: The entry made in the "treatment dates" field is not valid.

Solution: Treatment date must always be entered in "first" column. For hardcopy (paper) claims an entry is not required in the "last" column. DHS data entry will duplicate the entry into the "last" column. Both fields must be completed on automated tape submissions.

The exception would be for NTP Methadone Dosing services. A range of dates must be used when there is no break in service, therefore both fields must be completed at the program level on all claim submissions. For example, if NTP Methadone Dosing were for May 1, 2000 through May 10, 2000, the claim should show 01 for the first date and 10 last as the last date).

24. PROGRAM NOT AUTHORIZED

Problem: Program code is not authorized for the provider as billed.

Solution: Verify the accuracy of the provider number and the program code. If the codes are incorrect, enter the corrected codes in the correction field(s).

If these codes are correct, contact ADP for assistance with this correction. If required, ADP will take the necessary steps to have the DHS payor list updated.

25. SERVICE FUNCTION NOT AUTHORIZED

Problem: The service, as reported for program code, provider number, and/or service function code are not correct according to the payor list at DHS.

Solution: Review the codes for accuracy. If codes are incorrect, enter corrections in the correction field.

If all codes are correct, contact ADP for assistance. The ADP contact will check the DHS Provider Listing.

26. SERVICE NOT AUTHORIZED MO/YR

Problem: The reported service was not authorized for the Mo/Yr.

Solution: Review the reported Mo/Yr for accuracy. If it is incorrect make the correction in the correction field.

27. TO DAY > FROM DAY

Problem: The date submitted in the treatment dates "last" field is greater than the "first" date or there is a key entry error.

Solution: If the date entered in the "first" or "last" field is incorrect make the correction in the correction field (the date entered in the "last" field can never be greater than the date entered in the "first" field) except in the case of NTP Methadone Dosing.

28. UNITS GREATER THAN ALLOWED

Problem: The number of units being claimed is more than is allowed, as in the 20 unit (200 minute) limit for NTP counseling.

Solution: Reduce the number of units, not to exceed 20 units (200 minutes), and the dollar amount to correspond with the number of units.

29. UNITS NOT EQUAL TO DAYS

Problem: The reported units of service are not equal to the number of days in the range.

Solution: If the date range or the units of service are incorrect due to a key entry error, make the required corrections in the correction field.

If the reported date range is correct and the reported units are incorrect, enter the correct units in the correction field (making this change will result in the dollar amount being incorrect). If the reported units are reduced to less than originally reported, a notation will be required on your original claim for the cost report settlement.

If the reported units are correct and the reported date range is incorrect, enter the correct date range in the correction field.

NOTE: Units of service cannot be increased on an ECR. Submit a supplemental claim to increase the units of service for a client.

30. UNITS OF TIME >96

This message is for the Department of Mental Health.

31. UNITS/SERVICE IS NOT <= UNITS OF TIME

This message is for the Department of Mental Health.

32. ZERO CLAIMED

Problem: Units of service and dollar amounts were submitted as zero.

Solution: Units of service and dollar amounts must be submitted. The automated billing system will not accept zero. If units of service and the dollar amounts are zero because there were no services provided, this is not a charge. Delete the claim by putting an "X" in the override code box.

GENERAL INFORMATION AND INSTRUCTIONS

DUPLICATE ECR's

The Duplicate ECR contains data showing two claims submitted for the same client on the same day. It is also generated if too many dollars or units are claimed for a client.

Duplicate ECR's are also generated when an excess of 20 Narcotic Treatment Program (NTP) counseling units (combination of group and individual) (10-minute increments) are billed in one month. In this case, the suspended claim units must be reduced so that the units for that month will not exceed 20 units/200 minutes.

Duplicate errors will occur when a submitted claim is for the same service on the same day for the same client as an approved claim. The approved claim could have been for:

- Services billed using a different program code;
- Services billed for this client at another facility;
- Multiple services provided for the same client on the same day; or
- The combination of the submitted claim and the approved outpatient claims exceed two services on the same day for the same client (ADP allows for billing of only two services per client, per day).

The group of information on the Duplicate ECR is printed as follows:

- The first line of each group is the suspended claim; and
- The next line(s) is the approved claim(s), which caused the claim in the first line to suspend.
- The last item in the group is the correction box. This box is used to either override the duplicate error, delete the duplicate error, or correct the claim. The items in box are:

CLAIM ID	This is the claim ID number from the top right corner of the ADP 1584 of the claim in error, or the tape claim ID number supplied by the computer program.
OVERRIDE CODE	Enter the override code "Y" to approve the claim, or "X" to delete the claim from suspense, or leave blank if correcting other parts of the claim.

FIELD — This number is always “99”. This identifies the correction as a duplicate error correction.

Changes to the remaining fields in the correction box are made only when you are NOT overriding the claim. Enter data only in those fields which need to be corrected – DO NOT ENTER DATA IF WHAT IS SHOWN IS CORRECT:

Mo/Yr Serv	Month and year the client received the service. (Enter leading zeros – For example 0201 is for February 2001 while 1200 is for December 2000).
Days Serv	The first and last day of treatment. (Enter leading zeros – for example 0303 is the third day of the month and 1818 is the 18th of the month).
Units Time	Units of Time. This field should be zero or left blank.
Units Serv	Units of service provided. (Right justified, leading zeros are not required.
Billed Amount	Total dollars for services provided. (Right justified, leading zeros not required. Enter the cents also.)
Error Message	Supplied by the computer program based on the type of error.

OVERRIDE CODES:

- The **“X" override code** will delete a record from the automated billing system. The “X” requires no backup documentation.

- The **"Y" override code** will override multiple billing for the same client, on the same day, for the same service. A "Multiple Billing Override Certification" form ADP 7700 must be prepared and held at the provider site. DO NOT send the Multiple Billing Override Certification to ADP

ERROR MESSAGES – DUPLICATE ECR's

1. DUPLICATE SERVICE - NO OVERRIDE

Problem: The claim submitted is a duplicate service (either at the same facility or at a different facility) that is not permitted and there is no override.

Solution: The claim as submitted cannot be approved through the automated billing system. Review the fields for Mo/Yr of service, service days, units of service, and billed amount for accuracy. These are the only fields where corrections are permitted.

If any of these fields are incorrect, make the correction(s) in the correction fields. If the service days were submitted incorrectly or there is a key entry error, the correction to this field should allow the claim to be approved.

If fields are incorrect and there is no means for correcting them, enter an "X" in the override code field to delete the claim from the system. After the denied claim report has been received, resubmit a new claim with the required corrections, mark it "resubmission" (must be accompanied by a copy of the denied claim report).

If this claim is a duplicate it must be deleted by entering an "X" in the override code box. If the approved service (affixed with two ** on each side of the line) was billed by another provider it is the responsibility of the two providers to determine which facility should be billing DMC for the service. If it is determined that the approved service was an erroneous billing by a provider, that provider must complete an ADP 5035 form, Adjustment by Provider.

If there are questions regarding the claim history information, contact ADP.

2. MULTIPLE SERVICE - OVERRIDE OK

Problem: Two services have been reported for the same service, same client, same day.

Solution: Review the approved claim line for accuracy (line with two ** on each side.) If this line has been approved in error, contact ADP.

If the claim line (top line) on suspense has an error in the service days field, make the required correction in the correction field.

If the claim as reported is correct and it is an allowable second service provided for that day, follow the established county procedure to obtain certification of the service as appropriate and necessary. Upon receipt of certification, enter a "Y" in the override code field on the ECR, complete an ADP 7700 Multiple Billing Override Certification form (to be signed by the county representative) and submit to the county. The form is to be kept on file at the provider site to be produced, on request, for a monitoring or audit site visit. Do not send the Multiple Billing Override Certification to ADP.

3. DOLLARS OR UNITS > ALLOWED

Problem: The dollar amount billed exceeds the amount allowed or the number of units being claimed is more than is allowed, as in the 200 minute limit for NTP counseling.

Solution: Check to make certain the billed amount is not more than the maximum rate. Check to make sure the units of service for NTP counseling do not exceed the 200 minutes or 20 units limit. Make corrections as appropriate.

ECR CRITICAL FIELDS

The following is a list of critical and non-critical fields. Errors or blanks in the critical fields will generate an ECR.

The following numbers and descriptions refer to fields found on the form ADP1584.

1. CLAIM ID – CRITICAL The claim ID is the identifier essential for claim reference on both manually prepared and electronic media.

2. PROVIDER NAME – NON-CRITICAL The provider name is critical only to ADP.

3. PROVIDER CODE – CRITICAL The provider code is critical because it identifies the provider of services to be matched against the eligible Drug Medi-Cal provider file maintained by DHS.

4. CLAIM MM/YY – CRITICAL The claim month and year is a critical element for DHS, ADP and for provider reference.

5. PROGRAM CODE – CRITICAL The program code is a critical edit because it identifies the type of program for which a provider is billing. The following program codes are used for billing to the Department of Alcohol and Drug Programs:

   20 – Alcohol and Drug Services
   25 – Perinatal Services

6. MODE OF SERVICE – CRITICAL The mode of service is critical because it identifies the appropriate Drug Medi-Cal billing classification of services:

   12 – Outpatient Hospital
   17 – Clinic Services

7. Page ___ of ___ - NON-CRITICAL The page numbers are non-critical to claims processing but it is needed by ADP.

8. CLIENT NAME – NON-CRITICAL The client name is not critical because it may not be presented the same way each time on the county's media or the name used may not match letter for letter to the name on the client's eligibility file. However, the name field is used by DHS as a secondary check for client identification.

9. CLIENT RECORD NUMBER – NON-CRITICAL The client record number field is not edited. This information is primarily for provider use. This field has been increased to 9 digits for tape submissions.

10. SOCIAL SECURITY NUMBER – CRITICAL The Social Security Number is critical because it will be matched against the eligibility file to make sure the client is eligible for Drug Medi-Cal during the month/year of service.

11. YEAR OF BIRTH – CRITICAL The year of birth is a critical edit because it offers a reliable secondary check for client identification to be matched against the eligibility file.

12. SEX – CRITICAL Sex is used as a secondary check for client identification to be matched against the eligibility file.

13. RACE/ETHNICITY – NON-CRITICAL Race/ethnicity is not a critical edit because it has no impact on eligibility, however, this data is needed by DHS and ADP for statistical reports. It is also needed to meet federal reporting requirements.

14. DSM III DIAGNOSTIC CODE – CRITICAL The DSM III diagnostic code is a critical edit by ADP. This is to ensure that the services claimed are either alcohol or drug related.

15. MO/YR OF SERVICE – CRITICAL The month and year of service is critical because it marks the starting time for reimbursable claims to make sure they are billed to ADP within the two month billing limitation.

16. TREATMENT DATES (FIRST/LAST) – CRITICAL Treatment dates are critical and must be made available to meet federal reporting requirements.

17. DISCHARGED – NON-CRITICAL Discharge is not critical to ADP. If the provider enters something in this field other than #1, the provider will need to correct it by entering a “b” with a slash mark through it.

18. SERVICE FUNCTION CODE – CRITICAL The service function code is critical because it identifies the service as Drug Medi-Cal reimbursable and will aid in developing rates by specific service function.

19. UNITS OF TIME – NOT REPORTED TO ADP.

20. UNITS OF SERVICE – CRITICAL The units of service are critical because they measure the volume of service.

21. DOLLARS CLAIMED – CRITICAL Dollars claims is a critical edit because it shows the total amount billed to Drug Medi-Cal for specific clients.

22. PAGE TOTALS/GRAND TOTALS – CRITICAL On an ADP 1584 claim the units/page total amounts are critical because the DHS computer will compute the page total and compare it to the written page total. If the totals do not match the page will be rejected. The grand totals are critical on a tape or diskette claim. If the grand total does not match that computed by the computer the entire claim will be rejected and have to be corrected and resubmitted. If the line totals are incorrect the computer will compute the number of units of service and multiply the units times the rate and approve the appropriate approved units and total amount to be paid.

23. GOOD CAUSE – CRITICAL The good cause code is critical if the claim is late.

24. DUPLICATE OVERRIDE – CRITICAL The duplicate override code is critical if a client had two of the same service on the same day.

25. COUNSELOR INDICATORS – CRITICAL Counselor initials/identifier are needed in order for the State to more efficiently evaluate program activity by identifying staff time devoted to client counseling and to provide a more complete audit trail.

ECR QUICK CHECK

In order to reduce the possibility of seeing these same errors again, verify that the following has been done:

1. Is the ECR completed in **GREEN INK**?

2. Are all the errors addressed?

3. If Good Cause Certification forms and Multiple Billing Override Certifications forms are needed, are they completed and on file (do not send to ADP unless Good Cause code "D")?

4. If a "W" override is used, have the county and aid codes been provided?

5. If an override other than "W" is used, are all other fields for that correction left blank?